Bluegrass Outpatient Center

PERSONAL HISTORY FORM

Name: _____ D.O.B. _____

Primary Care Physician: _____

LATEX ALLERGY: I have Latex Sensitivity and/or Spina Bifida Yes No

1. I have had a reaction after handling/using poinsettia plants, balloons, rubber products or spandex Yes No
2. After a medical or dental appointment I have had: itching, tearing, fatigue, sneezing, runny nose. Yes No
3. After eating bananas, avocados, kiwi, or chestnuts I have had a reaction. Yes No

(If top statement and/or two or more from 1 – 3 are answered Yes — Latex Sticker Needed)

ILLNESSES, CONDITIONS or PROCEDURES: Have you had or do you currently have any of the following...

Arthritis	Yes	No	Currently Pregnant	Yes	No	Low Blood Pressure	Yes	No
Asthma or Emphysema	Yes	No	Diabetes	Yes	No	Metal Implants	Yes	No
Back Injury	Yes	No	Dizziness	Yes	No	Osteoporosis	Yes	No
Bleeding Disorder	Yes	No	Heart Attack	Yes	No	Pacemaker	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Circulation Problems	Yes	No	History of Seizures	Yes	No			

ALLERGIES: Please list any known allergies: _____

_____

SURGERIES: Please describe any surgeries: See Attached List _____ (check if applicable)

_____

_____

_____

_____

OTHER HEALTH CONDITIONS: Please describe any health conditions or procedures not listed above

_____

_____

PRESCRIPTIONS & OVER THE COUNTER MEDICATIONS: List any current prescriptions and/or medications you are taking

See Attached List _____ (check if applicable)

_____

_____

_____

_____

_____

I hereby certify the answers and statements given on this form are true, and significant information has not been withheld or omitted concerning my past and present state of health. I agree that the information given shall become part of my permanent medical record.

Signature: _____ Date: _____ Time: _____